

A Comparison Group Study of Solution-Focused Therapy versus “Treatment-as-Usual” for Behavior Problems in Children

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ABSTRACT. Behavior problems are the most common reason that children and adolescents are referred to treatment. This study presents a rationale for the application of solution-focused therapy to behavior problems and tests this assumption. Children who were referred from the school setting for behavior problems (N = 239) were treated with either solution-focused therapy or “treatment-as-usual” at a school of social work-sponsored mental health clinic. Hypotheses for this quasi-experimental, pretest/posttest design were that treatment engagement would be higher in the solution-focused therapy group and that the solution-focused therapy group children over the “treatment-as-usual” group would show greater improvement according to both parent and child reports. Logistic regression and MANOVA were the data analysis procedures to test hypotheses. Findings were as follows; the solution-focused therapy group had better treatment engagement, but there were no statistically significant differences between groups on perceptions of child behaviors from either parents (Conners Parent Rating Scale) or child reports (Feelings, Attitudes, and Behaviors Scale for Children). An examination of pre- and posttest differences over time for each group indicated similar improvements in treatment according to parent reports. Implications for practice and research are discussed. doi:10.1300/J079v33n01_07 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

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Solution-focused therapy has a unique orientation toward non-problem times. The purpose is to help people target and amplify resources and strengths toward change (Berg, 1994; de Jong & Berg, 2001; de Shazer, Berg, Lipchick, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986; O’Hanlon & Weiner-Davis, 1989). In solution-focused therapy, problems are viewed as surmountable when their corresponding solutions are broken down into small, concrete behavioral goals (Berg, 1994).

Once people have experienced small successes, change of a systemic nature is thought to occur (O’Hanlon & Weiner-Davis, 1989). That is, small change in one part of the system reverberates throughout the system, resulting in continued positive change. For more information on theoretical and conceptual underpinnings, please see De Jong and Berg (2001), O’Hanlon and Weiner-Davis (1989), and De Shazer (1994).

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EMPIRICAL SUPPORT FOR SOLUTION-FOCUSED THERAPY

Although a large body of anecdotal discussion about the effectiveness of solution-focused therapy has been generated, empirical evidence lags behind. A search of the following data bases, Social Work Abstracts, Psych-INFO, ERIC, CINAHL, Medline, and Sociological Abstracts, located the following evaluations of solution-focused therapy with child behavior problems. This literature will be reviewed and critiqued briefly below.

A couple of studies examined the use of solution-focused therapy in a children's mental health outpatient facility on different presenting problems, such as those involving parent-child relationships, school problems, and behavior problems at home (Lee, 1997; Wheeler, 1995). In these studies, no pretest data were collected but follow-up telephone interviews were conducted. In the Lee (1997) study, at six months 54 percent of the parents of the children stated that their goals had been achieved. Only about 10 percent (11%) said their goals were partially met, and a third (32%) said their goals had not been achieved. In the Wheeler study (1995), at three months, greater satisfaction was found in the solution-focused therapy group over the "routine" group, although statistical significance was not assessed. Limitations of these studies include the lack of standardized measures, the lack of a control/comparison group, and the biases associated with telephone interviews, which include social desirability and selection bias (those who remain at a residence with the same phone number will have greater stability and more resources than those who cannot be reached).

Littrell, Malia, and Vanderwood (1995) examined three conditions of brief therapy, one of which was solution-focused, administered in one session by high school counselors. All conditions were helpful in terms of allaying students' concerns and meeting treatment goals at both two and six weeks follow-up. Unfortunately, this study also lacked follow-up and standardized measures. In addition, it was limited by small sample size (approximately 20 children per treatment group). In another study implemented in the school setting, Thompson and Litrell (1998) reported positive results with

a small sample of children experiencing learning disabilities ($N = 12$) at two weeks following two sessions of solution-focused intervention. Lack of a control group and standardized measurement tools, as well as small sample size, however, limited study results. LaFountain and Garner (1996) further studied solution-focused therapy in the school system, administered through eight-week group sessions to 311 students, ranging from elementary to high school age. A majority (81%) reported goal attainment from pre- to posttest. Improvements in self-esteem and coping were also noted. Although sample size in this study was large and standardized measures were used, basic demographic information was missing, including the types of problems that brought children in for treatment, and no comparison or control group was employed.

Group treatment was also the focus of Zimmerman, Jacobsen, MacIntyre, and Watson (1996) with 42 parents who experienced conflict with their teens. Parents were randomly assigned to solution-focused therapy or wait-list control. At six weeks posttest, solution-focused therapy participants reported significant improvements on certain subscales of the Parenting Skills Inventory, including role image, communication, limit-setting, and rapport.

To summarize, the solution-focused studies with children have not consistently used pre-testing at baseline, standardized measures, adequate sample sizes, or comparison/control groups. In addition, although individual and group treatment modalities have been researched, solution-focused therapy has not been tested with more rigor in a family setting, despite the fact that solution-focused therapy originated from the field of family therapy.

Rationale for Solution-Focused Therapy with Child Behavior Problems

A particular area of treatment concern for children involves behavior problems, which are the most common reason that children and adolescents are referred to treatment. Between one-third to one-half of outpatient clinic referrals of children are for behavior problems (Kazdin, 1995).

In solution-focused therapy, behavior and cognitions, rather than feelings, are targeted for change, which may seem more relevant for the child who presents with behavior problems. By the time a family with a child behavior problem comes to treatment, a negative pattern has developed: the child “acts out”; the parent views the child negatively; the parent communicates this negative view to the child who then acts in a manner consistent with this view; and the spiral continues. In solution-focused treatment, the aim is to reverse this negative pattern, so that a positive spiral instead results: specific behaviors the parent wants to see are elicited; the child’s positive behavior is attended to and reinforced; the parent views the child more favorably; the child acts more consistently with this view; and the upward spiral continues.

Solution-focused therapy also accounts for the different client relationships that may typically present when a child comes to treatment for behavior problems. The “complainant” in solution-focused therapy is the client who comes to treatment initially seeming very motivated, but the motivation is mainly generated from wanting somebody else to change (Berg, 1994; de Jong & Berg, 2001). With behavior problems, parents are typically the “complainant.” In solution-focused therapy, the complainant is asked “coping questions,” questions designed to elicit the resources people have used to cope with difficult circumstances (Berg, 1994), such as having a child with behavior problems. Parents are also asked to state in concrete terms the behaviors they would like to see their child perform and are then directed, through various interventions, to focus on the times these behaviors are shown.

In solution-focused therapy, another client relationship type is the resistant or mandated client, the “visitor” (Berg, 1994). Children with behavior problems typically present as “the visitor.” They do not want to be in treatment, and usually other people have more problems with their behavior than they do with themselves. In solution-focused therapy, the mandated client is engaged in the treatment goal of not coming to counseling anymore and “getting their parents (or teachers) off their backs.” (See Corcoran, 2002a, for a more detailed discussion of how to use solution-focused therapy with children of different developmental stages, as well

as their parents, when behavior problems are the reason for treatment.)

Review of Dropout Literature with Child Conduct Problems

The solution-focused therapy literature has yet to focus on predictors of dropout from treatment and the types of client with the best treatment response. For information on dropout with treatment for child behavior problems, however, a substantial literature has accumulated on behavioral parent training with child behavior problems. Despite a great deal of empirical support for parent training (e.g., Serketich & Dumas, 1996), a significant proportion of families fail to respond to treatment—about 30 to 46 percent, according to Webster-Stratton (1990). Part of the reason for non-response involves the high rate of dropout. A review of this dropout literature indicates that certain parental factors, such as single-parenting and low household income, and child factors, such as severity of behavior problems and older age of child, are related to premature dropout (Dishion & Patterson, 1992; Kazdin, 1997).

The majority of studies from the parent training literature with child conduct problems have been conducted with white, middle-class families, and scant attention has been paid to the testing of the behavioral parent training model with conduct-disordered youth who are of an ethnic minority (Corcoran, 2000). However, Sue, Zane, and Young (1994), in a review on treatment studies with individuals of minority race, named dropout from treatment as a significant issue. Therefore, minority race could be seen as a risk factor for premature dropout from treatment with child conduct problems. Girls have typically also been missing from the treatment literature on conduct problems. It is unknown whether female or male children would have a greater risk of dropping out, and gender as a variable deserves more attention in the research.

PURPOSE AND HYPOTHESES

Given the proposed advantages for solution-focused therapy for child behavior problems and the lack of research on solution-fo-

cused therapy, the central purpose of the study reported here was to test a solution-focused intervention with child behavior problems. The research design was quasi-experimental, comparing an experimental condition, solution-focused therapy, with a comparison condition, "treatment-as-usual," over time from pretest to posttest with non-randomization to groups. ("Treatment-as-usual" was defined as services as normally delivered at the agency and will be delineated further in the methodology section [see pages 10-11]). The hypothesis was that the solution-focused therapy group would show statistically significant gains over the "treatment-as-usual" group in terms of improvement in child behaviors, according to both child and parent reports. (See Corcoran and Stephenson, 2000, for results of the solution-focused therapy group pretest, posttest findings.)

A secondary objective of the study was to explore differential dropout rates between the solution-focused therapy and the treatment-as-usual group. The hypothesis was that a higher rate of treatment engagement would be found in solution-focused therapy over the treatment-as-usual group. In a related vein, a third objective was to examine the predictors of dropout from the study to test whether factors found in the behavioral parent training literature were also associated with dropout from this sample.

The hypotheses were the following:

1. Parental factors associated with treatment dropout will be low household income, single-parent status, and being of minority race.
2. Child factors associated with treatment dropout will be severity of behavior problems and older age of child.

METHODOLOGY

Referral Process

Children were referred from the local school district in an urban southwest city by school counselors to a school of social work sponsored clinic. Presenting problems involved those relating to "behavior," such as aggression toward peers or parents, defiance

toward teachers, and conduct problems in school (i.e. non-completion of assignments, impulsivity, talking out-of-turn, and other classroom management problems). Problems could also be of a similar nature in the home, such as arguing with parents, fighting with siblings, and non-completion of homework or chores.

Referrals were screened out if they reported the need for treatment due to stressful life events, such as sexual abuse or if the child's family had recently suffered a death or divorce. The rationale for the screening process was so that the sample for the study could remain as homogeneous as possible.

Procedure

Treatment was delivered at a school of social work-sponsored mental health clinic, staffed by second-year Masters field students, to 239 children and their caregivers. Data collection began in Spring 1997 and was completed in Summer of 1999.

At the beginning of the initial session, the student interns administered an informed consent to the family, in which parents and children were told that treatment would consist of between four- and six sessions. All families who were invited to participate in the study agreed to do so. Family members were informed that if they did not feel like satisfactory progress had been achieved after the six-session limit, could continue with treatment after the posttest assessment. Altogether 85 families completed treatment, which is defined as attending between four and six sessions. One hundred fifty-four families dropped out, which is defined as attending between one and three sessions.

Measurement

Measures involved, first, a demographic information sheet, which parents completed. Behavior problems were assessed through the Conners' Parent Rating Scale (Conners, 1990), which parents completed, while the child completed the Feelings, Attitudes, and Behaviors Scale for Children (FAB-C) [Beitchaman, 1996]. The FAB-C is a 48-item, self-report (yes/no) inventory, normed for children ages

six to 13. The rationale for using the FAB-C is that three of the subscales have a direct relationship to the types of behavior problems for which the child may have been referred. The six subscales of the FAB-C comprises the following: conduct problems, self-image, worry, negative peer relations, antisocial attitudes, and lying. Higher scores indicate more problems. Internal consistency for the subscales ranges from .61 to .78 (Beitchman, 1996). For all the subscales, the mean 10-day test-retest reliability coefficient was .66, and the mean 28-day test-retest reliability was .60. Validity has been assessed through confirmatory factor analysis, which supports the multidimensional nature of the FAB-C. In addition, the FAB-C is able to discriminate between clinical and normal groups. Construct validity has also been assessed since the FAB-C appears to correlate positively with parent and teacher ratings on other standardized scales (Beitchman, 1996).

The Conners' Parent Rating Scale is a 48-item, Likert-type, parent-report inventory, evaluating the problem behavior of children between three and 17 (Conners, 1990). The Conners' Parent Rating Scale comprises the following six subscales, conduct, learning, psychosomatic symptoms, impulsive-hyperactive symptoms, hyperactivity index, and anxiety. The rationale for using the Conners' Parent Rating Scale is that three of the subscales have a direct relationship to the types of behavior problems for which the child may have been referred. Higher scores indicate more problems. Reliability has been established through inter-rater reliabilities, ranging from .46 (Psychosomatic) to .57 (Conduct Problem) with a mean correlation of .51, and item-total correlations, ranging from .13 to .65 (Conners, 1990). Validity has been assessed through a factor analysis, which confirmed five principal factors corresponding to the subscales of the Conners' Parent Rating Scale.

Students were trained on how to administer the measures by the principle investigator. Students, therefore, were the ones responsible for collecting measures in the first session prior to beginning treatment (pretest) and at the end of the last session (posttest).

Solution-Focused Intervention

The solution-focused intervention took place between Spring of 1997 and Summer of 1998. Twenty student interns were trained in solution-focused therapy by the author using videotaped demonstrations by Insoo Kim Berg, lecture, discussion, and role-plays on the following interventions, which were also used in the sessions by the students: (1) joining; (2) how to assess and intervene with different client types; (3) the phrasing of solution-focused questioning; (4) exception-finding; (5) externalizing the problem; (6) the miracle question; (7) goal-setting and scaling questions; (8) the pessimistic sequence; and (9) termination. (Space precludes detailing these various interventions but the interested reader is referred to deJong & Berg, [1998]; Berg [1994]; O'Hanlon & Weiner-Davis [1989].)

Students were requested to video or audiotape each of their sessions with clients. Supervision comprised weekly individual meetings with students in which discussion revolved around listening/viewing of taped sessions. Because the age range of children in the study were between five and 17, part of supervision involved how to adapt solution-focused therapy to the different age ranges of children that were seen. (For more information on the adaptation of techniques for children of different developmental stages, please see Corcoran, 2002a).

Comparison Group

The comparison group originally comprised a "waiting-list" control condition. However, attempts to collect information from the waiting-list control group from various means—mail, telephone, and home visits—proved futile, and families on the waiting-list were either unable to be contacted or were uninterested in pursuing services. Therefore, in order to obtain a comparison group, the decision was made that after data were collected from the solution-focused therapy experimental group that a "treatment-as-usual" comparison group would be administered.

Obviously, it would have been advantageous for treatment and comparison groups to operate concurrently with randomization to groups. However, treatment integrity was an is-

sue. It was thought that if student interns were trained separately in solution-focused therapy and "treatment-as-usual," they might start to use techniques and methods from the other model as they discussed their cases amongst themselves and attended staffings. Therefore, the student interns who were trained in the comparison group were different than those in the solution-focused group. Implementation of the "treatment-as-usual" condition began in Fall 1998 and was completed in Summer of 1999.

The "treatment-as-usual" comparison group was a family treatment, relying heavily on cognitive-behavioral interventions. Behavioral parent training was a central focus in which parents learned to track behaviorally specific goals, to reinforce appropriate behavior with praise, tokens, privileges, and other rewards, to ignore minor negative behaviors, and to punish inappropriate behavior with time out and removal of privileges. Other cognitive-behavioral interventions used were problem-solving, social skills training with children, and communication skills training with families. Structural family therapy techniques were also used in which parents, through direction in the session and homework assignments, were encouraged to work together with the other adult caregivers in the child's life, to take charge of their children's behavior. Twenty interns implemented the "treatment-as-usual" condition. Students received on-going training in weekly two-hour staff meetings, and were supervised individually for one hour each.

SIMILARITIES AND DIFFERENCES BETWEEN TREATMENT GROUPS

Both the solution-focused therapy and the "treatment-as-usual" were offered for the same number of sessions (four to six) as primarily family treatments. Like cognitive-behavioral therapy, solution-focused therapy emphasizes changes in cognitions and behaviors, with a focus on specific, behavioral goals. The difference is that solution-focused therapy concentrates on what is already working for the client, their strengths and resources, while cognitive-behavioral therapy (the primary basis of "treatment-as-usual") focuses on training children and their parents to overcome their skill deficits.

(For a more complete discussion of the differences between solution-focused and cognitive-behavioral therapies, please see Corcoran, 2002b.)

Treatments were both administered by 40 second-year Master of Social Work field students. Both conditions had similar proportions of students who were first semester and second semester of their second year. The majority of students were of female gender (87%) and of white race as reflective of the characteristics nationally of students attending Master of Social Work programs. Students varied in their prior experience although all had completed a first-year Masters field placement. Students overall tended to have very little prior clinical experience before their internship.

Treatment Fidelity

Although treatment fidelity was not examined in a systematic way for the solution-focused therapy group, supervision of each intern was conducted with their "most challenging," audio- and videotaped sessions to ensure that interns were staying in line with solution-focused techniques and to give further direction as needed. Additionally, taped sessions were later transcribed and used for teaching purposes on solution-focused therapy.

While training and supervision time were equally intensive for the two treatment conditions, the "treatment-as-usual" sessions were not taped as this condition was seen as an eclectic treatment model. The approaches used depended on the particular intern's preferences with input from field supervisors, who tended to support cognitive-behavioral methods. Supervisors were instructed not to teach or encourage solution-focused approaches.

DATA ANALYSIS

Data analysis began with frequency counts on demographic variables and t-tests and chi-square analyses to determine differences between experimental and comparison group variables. Multivariate analysis of variance (MANOVA) was used to determine if the independent variables (treatment or comparison group) differed on the 12 dependent variables

over time (pre- to posttest). Multivariate analyses of covariance (MANCOVA) were then performed with age, race, gender, and income subsequently entered as co-variables.

Logistic regression analysis was conducted to determine the factors associated with treatment engagement for both the treatment group (solution-focused therapy) and the comparison group (treatment-as-usual). The outcome was dichotomous in that each subject in each condition belonged to either a pretest-only group or a group that had completed both pretest and posttest measures. The predictors included factors that have been identified in the literature and include interval (child age, child behavior problems), ordinal (parental income) and nominal (parental employment, marital status, race, child gender, type of treatment) variables. The sample size of the study ($N = 239$) was sufficient to support a logistic regression as 15 subjects are needed to support one predictor (Demaris, 1992). With eight predictors, the sample size was over a hundred more than necessary.

RESULTS

Frequencies

For complete information on the demographics of the total sample, for those who completed treatment, and for those who dropped out of treatment, for both the solution-focused therapy and "treatment-as-usual" comparison group, please see Table 1. Overall, 139 families began the solution-focused therapy condition; 58 (41.2%) completed between four and six sessions and filled out the posttest measurement assessment, and 81 (58%) dropped out. One hundred families began the "treatment-as-usual" comparison group; 27 (27%) completed treatment, and 73 (73%) dropped out. The majority of children who began treatment were male (63% for solution-focused therapy and 61% for "treatment-as-usual"). Children were between the ages of five and 17, with 10 as the mean age for both the treatment and comparison group. The majority of the families were white (78% for solution-focused therapy, 69% for treatment-as-usual). Mothers usually accompanied their children to treatment (75%

for the solution-focused therapy and 74% treatment-as-usual)¹. The majority of parents in the study were either married (38% for solution-focused therapy, 42% for treatment-as-usual) or divorced and not re-married (27% for solution-focused therapy, 36% for treatment-as-usual). The average income for the solution-focused therapy group was between \$20,000 and \$29,000, and the average income for the treatment-as-usual comparison group was between \$30,000 and \$39,000.

T-Tests and Chi-Square Analyses

T-tests for ordinal and ratio level data and chi-square analysis for nominal-level data indicated that there were no statistically significant differences on the demographic variables between the treatment and comparison groups, which were run for the total sample, for those who completed treatment (attended between four and six sessions and completed posttest measures), and for those who dropped out of treatment (attended less than four sessions). Please see Table 2.

MANOVA

Tabachnik and Fidell (1996) advise that in order to use the dependent variables in a MANOVA that they should not be too strongly correlated; nor should there be an absence of correlation between variables. A correlation matrix was therefore performed with the dependent variables. Two variables, the FAB-C lie and antisocial attitudes subscales were consistently found to lack relationship with the other dependent variables, and were, as a result, removed from the MANOVA. With the remaining variables, a 2 (treatment group) \times 2 (time) MANOVA was performed to determine if there were between group differences between the experimental and comparison group on the dependent measures over time. A non-significant interactional effect was found; $F(10, 70) = .758$, $p = .668$. As can be seen from Table 3, for both groups, subscale scores tended to decrease (improve) over time, at least according to parent reports.

TABLE 1. Demographic information for solution-focused and "treatment-as-usual" comparison group for total samples, those who completed treatment, and those who dropped out of treatment

Demographic Variables	Total solution-focused sample (N = 139)	Completers* of solution-focused (N = 58)	Drop-outs** of solution-focused (N = 81)	Total "treatment as usual" (N = 100)	Completers of "treatment as usual" (N = 27)	Dropouts of "treatment as usual" (N = 73)
<i>Gender</i>						
Male	87 (63%)	37 (64%)	50 (62%)	61 (61%)	15 (56%)	46 (63%)
Female	52 (37%)	21 (36%)	31 (38%)	39 (39%)	12 (44%)	27 (37%)
<i>Age of Child</i>						
5-6	11 (8%)	3 (5%)	8 (10%)	7 (7%)	3 (11%)	4 (5%)***
7-9	48 (35%)	23 (40%)	25 (31%)	34 (34%)	8 (30%)	26 (36%)
10-12	53 (38%)	21 (36%)	32 (39%)	39 (39%)	12 (44%)	27 (37%)
13-15	19 (14%)	8 (14%)	11 (14%)	13 (13%)	3 (11%)	10 (14%)
16-17	8 (6%)	3 (5%)	5 (6%)	7 (7%)	1 (4%)	6 (8%)
<i>Race of Child</i>						
White	108 (78%)	47 (81%)	61 (75%)	69 (69%)	18 (67%)	51 (70%)
African American	11 (8%)	3 (5%)	8 (10%)	17 (17%)	4 (15%)	13 (18%)
Hispanic	12 (9%)	3 (5%)	9 (11%)	8 (8%)	2 (7%)	6 (8%)
Other	8 (6%)	5 (9%)	3 (4%)	6 (6%)	3 (11%)	3 (4%)
<i>Employee status of parent</i>						
Employed	111 (80%)	45 (78%)	66 (81%)	80 (80%)	21 (78%)	59 (81%)
Unemployed	28 (21%)	13 (22%)	15 (19%)	20 (20%)	6 (22%)	14 (19%)
<i>Income</i>						
< \$10,000	20 (14%)	5 (9%)	16 (20%)	10 (10%)	3 (11%)	7 (10%)
\$10,000-\$19,999	29 (21%)	10 (17%)	19 (23%)	10 (10%)	3 (11%)	7 (10%)
\$20,000-\$29,999	29 (21%)	14 (24%)	14 (17%)	37 (37%)	7 (26%)	30 (41%)
\$30,000-\$39,999	25 (18%)	12 (21%)	13 (16%)	14 (14%)	6 (22%)	8 (11%)
\$40,000-\$49,999	17 (12%)	6 (10%)	11 (14%)	12 (12%)	4 (15%)	8 (11%)
> \$50,000	19 (14%)	11 (19%)	8 (10%)	17 (17%)	4 (15%)	13 (18%)
<i>Marital Status</i>						
Married	53 (38%)	24 (41%)	29 (36%)	42 (42%)	13 (48%)	29 (40%)
Divorced	38 (27%)	14 (24%)	24 (30%)	36 (36%)	11 (41%)	25 (34%)
Single, never married	12 (9%)	6 (10%)	6 (7%)	5 (5%)	1 (4%)	4 (5%)
Living with a partner	10 (7%)	2 (3%)	8 (10%)	6 (6%)	0 (0%)	6 (8%)
Remarried	13 (9%)	5 (9%)	8 (10%)	5 (5%)	1 (5%)	4 (5%)
Other	13 (9%)	7 (12%)	6 (7%)	6 (6%)	1 (6%)	5 (7%)
<i>Relationship of parent to child?****</i>						
Mother	104 (75%)	48 (83%)	56 (69%)	74 (74%)	21 (78%)	53 (73%)
Father	16 (12%)	5 (9%)	11 (14%)	13 (13%)	5 (19%)	8 (11%)
Grandparent	9 (6%)	4 (7%)	5 (6%)	4 (4%)	0 (0%)	4 (5%)
Other	10 (7%)	1 (2%)	9 (11%)	9 (9%)	1 (4%)	8 (11%)

* "Completers" are those that completed between four and six sessions of treatment and completed posttest measurement package.

** "Dropouts" are those that did not complete between four and six sessions.

*** Some sums of percentages may be greater than 100% due to rounding.

**** "Parent" refers to the person involved in treatment with the child.

TABLE 2. Comparison of Solution-Focused vs. "Treatment-as-Usual" for the Total Sample, for Completers, and for Dropouts

Demographic Variables	Total Solution-Focused vs. "Treatment-as-Usual"	Completers of Solution-Focused vs. "Treatment-as-Usual"	Dropouts of Solution-Focused vs. "Treatment-as-Usual"
T-Tests: <i>t</i> , <i>p</i>			
<i>Age of Child</i>	-.951, <i>p</i> = .343	-.001, <i>p</i> = .999	-1.080, <i>p</i> = .281
<i>Income</i>	-1.350, <i>p</i> = .179	-.022, <i>p</i> = .983	-1.930, <i>p</i> = .056
Chi-Square: χ^2 , <i>p</i>			
<i>Gender</i>	1.490, <i>p</i> = .474	.526, <i>p</i> = .468	1.130, <i>p</i> = .569
<i>Race of Child</i>	8.790, <i>p</i> = .186	5.354, <i>p</i> = .374	5.890, <i>p</i> = .435
<i>Employee status of parent</i>	.055, <i>p</i> = .973	.000, <i>p</i> = .984	.017, <i>p</i> = .991
<i>Marital Status</i>	6.220, <i>p</i> = .400	5.839, <i>p</i> = .322	2.702, <i>p</i> = .845
<i>Relationship to Child</i>	8.180, <i>p</i> = .146	3.759, <i>p</i> = .289	7.260, <i>p</i> = .202

TABLE 3. Mean Subscale Ratings for the Conners' Parent Rating Scales and the FAB-C, Pretest/Posttest, for the Solution-Focused and the "Treatment-as-Usual" Groups

Scale	Solution-Focused Therapy (N = 56)		"Treatment-as-Usual" (N = 27)	
	Pretest M (SD)	Posttest M (SD)	Pretest M (SD)	Posttest M (SD)
Conners' Parent Rating Scales				
1. Conduct	11.3 (4.9)	8.6 (5.0)	12.3 (6.2)	9.7 (6.0)
2. Learning Problem	6.6 (2.7)	5.0 (2.8)	6.4 (3.2)	4.7 (2.6)
3. Psychosomatic	2.5 (2.1)	1.8 (2.0)	2.6 (2.4)	2.4 (2.6)
4. Impulsive-Hyperactivity	7.0 (2.7)	5.8 (2.9)	7.1 (3.4)	5.6 (3.6)
5. Anxiety	4.0 (2.8)	3.4 (2.6)	4.7 (3.4)	3.8 (3.2)
6. Hyperactivity Index	16.0 (5.1)	12.1 (6.2)	15.8 (7.8)	11.8 (7.2)
FAB-C				
Conduct	16.7 (2.7)	18.0 (2.5)	17.5 (3.2)	18.4 (2.3)
Lying	14.0 (2.1)	14.0 (2.0)	11.4 (2.1)	15.8 (2.9)
Self-Image	8.4 (1.5)	7.8 (1.3)	7.9 (1.0)	8.0 (1.5)
Worry	10.4 (2.3)	10.8 (2.1)	10.1 (2.3)	10.5 (2.5)
Negative Peer Relations	7.6 (2.0)	7.9 (1.9)	7.7 (2.0)	8.3 (2.0)
Antisocial	9.2 (1.4)	9.1 (1.3)	9.5 (1.73)	9.68 (1.55)

Logistic Regression

Logistic regression was employed using SPSS (1998) software. The enter procedure was used to test the predictor with the Wald statistic employed to select variables for removal. See Table 4 for results of the logistic regression model.

The odds ratio [$\exp(b_i)$] assesses the individual contributions of independent variables that entered the model (Hosmer & Lemeshow, 1989). For continuous independent variables, the odds ratio approximates how much more likely (or unlikely) the outcome is for every unit increase in the predictor. Other than type of treatment (solution-focused therapy or "treatment-as-usual"), which was significant at the .01 level, no other predictors were statistically significant. The adequacy of the final overall model is reported in terms of the percent correctly classified and the Hosmer and Lemeshow goodness of fit statistic (Hosmer & Lemeshow, 1989). The percent correctly classified for each condition was calculated by using a predicted probability of 0.5 as the cut-off for classifying an outcome. Of those who had completed pre- and posttests, 22.4% were correctly classified, while 92.9% of the non-completers were correctly classified. Overall, 67.8% were correctly classified with the final prediction model. The Hosmer and Lemeshow goodness-of-fit statistic was generated and a

TABLE 4. Logistic Regression for Engagement in Treatment

	Odds Ratio	Lower CI	Upper CI
Variable			
Child Factors			
Age	.970	.865	1.088
Gender	1.012	.553	1.851
Race			
African-American (White referent)	.740	.276	1.984
Mexican-American	.603	.196	1.850
Severity of Problems			
Conduct Problems	1.010	.946	1.078
Hyperactive Problems	.995	.973	1.018
Impulsive-Hyperactivity	.995	.882	1.121
Parent Factors			
Unemployed (Employed referent)	1.285	.637	2.591
Income	1.192	.959	1.481
Marital Status	.396	.099	1.590
Divorced (Married referent)	1.226	.572	2.629
Single, never married	1.392	.401	4.836
Living with a Partner	.661	.218	2.005
Remarried	1.387	.454	4.243
Treatment Factors			
Comparison Group (experimental group as referent)	*.466	.256	.850
Hosmer-Lemeshow Goodness of Fit	5.748, 8 df, p = .676		

*vp = .01

value of 5.75 was produced, a non-significant value, indicating no serious problems with the overall fit of the model.

DISCUSSION

The main objective of this study was to examine the differences between solution-focused therapy and "treatment-as-usual" for child behavior problems over time. The hypothesis was not supported: solution-focused therapy did not surpass the "treatment-as-usual" condition on outcome measures, although both groups made improvements over time. Perhaps because the comparison group

relied so heavily upon cognitive-behavioral therapy, which has shown to be empirically validated for child behavior problems (Bennett & Gibbons, 2000; Serketich & Dumas, 1996), it was not reasonable to expect the solution-focused condition to outperform "treatment-as-usual." At the same time, it is encouraging that both conditions were able to produce change in this brief amount of time (between four and six sessions).

However, it must be noted that these findings only apply to those that completed treatment, and dropout for both conditions was high. In the solution-focused therapy condition, only 42 percent of families completed both pre- and posttest measures. However, the treatment-as-usual comparison condition displayed an even higher rate of dropout: 73%. The difference between dropout rates for the two conditions proved to be statistically significant at the .05 level. Indeed, treatment condition was the only factor significant in the logistic regression model. Other factors associated with dropout in the parent training literature did not seem particularly predictive of dropout with this sample. Other reasons, beyond parent and child characteristics, may therefore account for dropout.

In considering some of the reasons families seemed to more readily engage in the solution-focused treatment, several possibilities exist. First, the emphasis on solution-focused therapy is on strengths and resources. Questions in the model are designed to elicit how people already use their resources to resolve problems, and children and families are complimented on these strengths. Parents might have felt better about themselves and the treatment and felt more hopeful about the possibility of change; as a result, they may have felt more inclined to continue when compared to the treatment-as-usual comparison group.

Another possible reason for increased retention in solution-focused therapy is that when children are referred for behavior problems, parents tend to expect that treatment will address their child's behavior. In both conditions, student therapist interns reported that some parents questioned why the majority of the counseling time was not spent with the child alone. Solution-focused therapy, though, was more directly focused on the child's behavior whereas the treatment-as-usual comparison condition

usually concentrated on helping parents with their skills via parent training in order to influence their child's behavior. The focus of solution-focused therapy on goals that people bring into treatment (child behavior problems) may have more relevance and face validity for parents.

In addition, the source of the referral must be considered in explaining the difference in drop-out between the solution-focused and treatment-as-usual conditions. Children were referred from the school system, usually because problems with their conduct were evident in the classroom. Often similar issues were present with the child's behavior at home, but sometimes problems were limited to the school setting. In these cases, focusing on parenting skills and family issues may have had reduced validity for parents. In contrast, the solution-focused emphasis was on how parents and children could work together, or how parents could help their children change their behavior to "prove" to the school system that treatment was no longer necessary.

LIMITATIONS AND SUGGESTIONS FOR RESEARCH

A number of limitations might possibly influence the results of this study. First, a limited number of measures were used, and these included only self-report inventories. However, these choices were made to reduce burden on family members and to interfere as little as possible with services they were seeking.

Although teacher reports could have also been taken, given the nature of the referrals (school referrals for behavior problems), and these would have provided triangulation of data, confidentiality issues posed an obstacle. Counselors from schools were the primary source of referrals. They might have received information about a particular child from a teacher, but sometimes school counselors handled students' problems outside teacher involvement. To survey teacher perceptions of child classroom behaviors would have violated the children's and their families right to confidentiality of treatment. However, another option would have been to gain access to school-level data on attendance, academic

achievement, and conduct problems. Future work could include this type of data in the research.

Internal validity problems might also pose some methodological problems to the study. Perhaps the most salient problem involves history in that comparison treatment conditions occurred subsequent in time. It could be that different types of clients, not reflected in the demographic characteristics studied, accounted for differences between groups that had little to do with the intervention method. Or, for instance, different types of student interns involved in the two different treatment conditions were attracted to the clinic for their field placement, which might have accounted for findings of the study. Although interns tended to be similar in terms of educational level (second-year Masters student), level of experience (minimal clinical experience), race (majority white), and gender (female), characteristics of student-practitioners were not tracked systematically. Future research on solution-focused therapy should strive toward tracking characteristics of practitioners. Engagement and outcome may have more to do with the process of therapy and the interaction patterns between practitioner and client (Beyebach & Carranza, 1997; Beyebach, Morejon, Palenuela, & Rodriques-Arias, 1996), rather than particular client characteristics. Toward this end, the videotaped interviews of first sessions of the solution-focused therapy study have been transcribed and certain attributional processes are being explored (see Corcoran, 2003).

As discussed, it might have been unreasonable to expect solution-focused therapy to outperform the comparison group when "treatment-as-usual" was already loaded with cognitive-behavioral components. Despite the challenges of comparing treatment against a no-treatment control, future work should strive toward control groups with randomization to groups.

An additional weakness of the study was that treatment fidelity was not examined in a systematic way. It could be that student interns deviated from certain techniques in a way that made either the solution-focused therapy less effective, or they were unable to follow through certain interventions the way they were developed for the "treatment-as-usual" condition.

Future studies should ensure that treatment is carried out in a way that is standardized in fashion.

Another limitation of the study involves the lack of follow-up, which precludes knowledge about the progress on child behavior problems after treatment was terminated. Despite the difficulties of obtaining information after treatment has been terminated, future researchers are urged to consider tracking behavior over time beyond the posttest period. Such contact could also perhaps seek to determine the reasons for families not returning for scheduled appointments, if applicable.

CONCLUSION

Although no significant differences were found between solution-focused therapy and a "treatment-as-usual" comparison group for the treatment of child behavior problems, this study points to further directions for improved methodology in future solution-focused therapy studies.

NOTE

1. In the few cases in which both mother and father accompanied the child to treatment, both parents completed measures and responses to Conners subscales were averaged.

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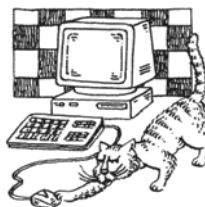
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